Aurora Mental Health & Recovery

Asian Pacific Development Center
A subsidiary of Aurora Mental Health & Recovery

Clinical Records Dept. 1290 Chambers Road, Aurora, CO 80011
Phone 303.617.2336 · Fax 303.617.2445 · ClinicalRecords@AuroraMHR.org

RELEASE OF INFORMATION OR AUTHORIZATION

_____ _____ ____/____/_____ _____
Client Name (please print) Social Security # Date of Birth CID

Please circle or check one or both below if applicable:

I authorize ☐ **Aurora Mental Health & Recovery** and/or ☐ **Asian Pacific Development Center**

to exchange information with: _____
Name of Person/Doctor/Agency/Hospital/School District

_____ _____ _____ _____
Phone Fax Street Address City / State / Zip Code

I request that records/information be released in the following format:
☐ Verbal Information ☐ Printed ☐ Electronic ☐ Certified

I request that the records/information be released in the following manner:
☐ Mail ☐ Fax ☐ Picked up
☐ Secure Email *(If selected, please provide email:* _____ *)*

The information to be disclosed includes the following checked documentation:
☐ Complete Record *Or check below:*

☐ Medication History ☐ Psychiatric / Psychological Evaluations ☐ Progress Notes

☐ Care Plans ☐ Discharge Summaries ☐ Intake Assessment

☐ Other _____

Dates include: From _____ To _____ ☐ All Dates ☐ Last 4 weeks ☐ Last 6 months
☐ Last year ☐ Other: _____

The purpose for the release is: ☐ Continuity of care ☐ Other: _____

I UNDERSTAND that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Information about a Substance Use Disorder may not be re-disclosed by the recipient without my written consent unless otherwise provided for in the relevant rules [42 C.F.R. Part 2].

I UNDERSTAND that if I chose to disclose information indicating HIV / AIDS, that information may be contained in the records to be released to the above-named individual or agency.

Please continue on to Sign and Date Page 2

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I UNDERSTAND that I may revoke this Authorization at any time by giving written notice to the Center, except to the extent that the Center has already taken action on this request. This Authorization will expire on _____ (date), or, if left blank, two years from the date of my signature. I release the Center from all liability for disclosing the requested information.

I UNDERSTAND that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this Authorization.

NOTICE TO THE RECIPIENT OF THE INFORMATION

Federal law (42 C.F.R. Part 2) prohibits unauthorized disclosure of these records. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Please print name of Legal Representative Phone

If you are not the client, please identify your authority to act on the client's behalf by circling one of the following:

☐Parent of Minor ☐Guardian ☐GAL ☐MDPOA

☐Personal Representative - Executor of Estate (Documentation Required)

I hereby revoke this Authorization to Release Information.

_____ _____
Signature of Client or Legal Representative Date

Revised 1/18/23